

**§ 433.56 Classes of health care services and providers defined.**

(a) For purposes of this subpart, each of the following will be considered as a separate class of health care items or services:

- (1) Inpatient hospital services;
- (2) Outpatient hospital services;
- (3) Nursing facility services (other than services of intermediate care facilities for individuals with intellectual disabilities);
- (4) Intermediate care facility services for individuals with intellectual disabilities, and similar services furnished by community-based residences for individuals with intellectual disabilities, under a waiver under section 1915(c) of the Act, in a State in which, as of December 24, 1992, at least 85 percent of such facilities were classified as ICF/IIDs prior to the grant of the waiver;
- (5) Physician services;
- (6) Home health care services;
- (7) Outpatient prescription drugs;
- (8) Services of managed care organizations (including health maintenance organizations, preferred provider organizations);
- (9) Ambulatory surgical center services, as described for purposes of the Medicare program in section 1832(a)(2)(F)(i) of the Social Security Act. These services are defined to include facility services only and do not include surgical procedures;
- (10) Dental services;
- (11) Podiatric services;
- (12) Chiropractic services;
- (13) Optometric/optician services;
- (14) Psychological services;
- (15) Therapist services, defined to include physical therapy, speech therapy, occupational therapy, respiratory therapy, audiological services, and rehabilitative specialist services;
- (16) Nursing services, defined to include all nursing services, including services of nurse midwives, nurse practitioners, and private duty nurses;
- (17) Laboratory and x-ray services, defined as services provided in a licensed, free-standing laboratory or x-ray facility. This definition does not include laboratory or x-ray services provided in a physician's office, hospital inpatient department, or hospital outpatient department;

(18) Emergency ambulance services; and

(19) Other health care items or services not listed above on which the State has enacted a licensing or certification fee, subject to the following:

- (i) The fee must be broad based and uniform or the State must receive a waiver of these requirements;
- (ii) The payer of the fee cannot be held harmless; and
- (iii) The aggregate amount of the fee cannot exceed the State's estimated cost of operating the licensing or certification program.

(b) Taxes that pertain to each class must apply to all items and services within the class, regardless of whether the items and services are furnished by or through a Medicaid-certified or licensed provider.

[57 FR 55138, Nov. 24, 1992, as amended at 58 FR 43180, Aug. 13, 1993; 73 FR 9698, Feb. 22, 2008]

**§ 433.57 General rules regarding revenues from provider-related donations and health care-related taxes.**

Effective January 1, 1992, CMS will deduct from a State's expenditures for medical assistance, before calculating FFP, funds from provider-related donations and revenues generated by health care-related taxes received by a State or unit of local government, in accordance with the requirements, conditions, and limitations of this subpart, if the donations and taxes are not—

- (a) Permissible provider-related donations, as specified in § 433.66(b); or
- (b) Health care-related taxes, as specified in § 433.68(b).

[57 FR 55138, Nov. 24, 1992, as amended at 73 FR 9698, Feb. 22, 2008]

**§§ 433.58–433.60 [Reserved]****§ 433.66 Permissible provider-related donations.**

(a) *General rule.* (1) Except as specified in paragraph (a)(2) of this section, a State may receive revenues from provider-related donations without a reduction in FFP, only in accordance with the requirements of this section.

(2) The provisions of this section relating to provider-related donations for outstationed eligibility workers are effective on October 1, 1992.